“Building a Responsive Community”

Study of Services for Disabled and Elderly Residents of New Hanover County

March 2005

I. New Hanover County Building a Responsive Committee:

New Hanover County Department of Aging	Annette Crumpton
Cape Fear Council of Governments	Jane Jones
Britthaven Nursing Home	Angie Barr
Cape Fear Council of Governments	Holly Henderson
Cape Fear Home Health	Lisa Leftwich
Services for the Blind/Visually Impaired	Eddie Weaver
Services for Deaf /Hard of Hearing	Margie Gilmore
Hospice of the Lower Cape Fear	Zorie Brown
North Carolina Division of Aging/Adult Services	Nancy Warren
New Hanover County Department of Aging	Faye Jacobs
Community Alternatives Program	Athena Brown
ARC	Joanne Cain
ACC	Jodie Foley
Alzheimer's Association	Kay Walker
Independent Living	Margaret Craig
Congressman McIntyre Office	Katherine Thompson
New Hanover County Ombudsman	Harvin Quidas
New Hanover County Emergency Management	Warren Lee
NHC Protective Services Unit (NHC DSS)	Pat Jessup
Elderhaus, Inc.	Linda Pearce
Wilmington Housing Authority	Catercia McCoy
Comfort Keepers	Craig Magill
NHC Department of Social Services	LaVaugh NeSmith
Southeastern Mental Health Services	Carolyn Craddock
Consumer/ Minister	Merrill Holden
Consumer/ Retired Nurse	Betty Grace
WAVE Transit	Deborah Houston
DMS Services, Inc.	Doreatha Strone
United Health Care	Sil Anderson
NHC Assistant County Manager	Pat Melvin

New Hanover Regional Medical Center	Marsha McIntosh
Pine Valley Methodist Church	Buck Norton
NHC Health Department	Betsy Summey

II. Authorization for the New Hanover County Study

In July 2003, Ted Davis, Chairperson for the New Hanover County Board of Commissioners prepared a letter stating the support of the New Hanover Commissioners for the NHC Department of Aging's application to be considered as one of the counties chosen to implement the Communications and Coordination initiative to Strengthen Long Term Care Services.

The NHC Department of Aging returned to the Commissioners during a September 2004 meeting and presented an update of the committee's work and announcement of the September 2004 Community Forum.

The Commissioners have received on going updates of the Building a Responsive Community Committee's work through reports provided by Pat Melvin, Assistant County Manager and member of the BRAC committee.

III. Building a Responsive Community Project Summary:

June 2003, the New Hanover County Department of Aging responded to the NC Division of Aging and Adult Service's (DAAS) request to submit a proposal to study the Communications and Coordination of Long Term Care services for the elderly and disabled populations in New Hanover County. New Hanover County was chosen as one of the two counties in North Carolina to implement this study.

The Department of Aging gained the support of the New Hanover County Commissioners and embarked on the journey to examine the strengths and weaknesses of the targeted long-term care services for disabled and elderly in New Hanover County, develop a report card on the study and develop a plan to address the future needs of these populations.

A: Committee Organizational Process

The first task involved establishment of a community wide committee. The NHC Department of Aging Director and Area Agency on Aging Administrator sent invitations to over fifty public/ non-profit agencies, churches and consumers connected with the elderly and disabled populations asking for their support and participation in the project. New Hanover County had a previous history working with community agencies in a project titled ROAR and built on this experience for the long-term care study.

Task 1 :

The new group named their project, "*Building a Responsive Community*". The initial meeting was held late October 2003. The group continues to meet the second Monday of each month. The first task of the Building a Responsive Community Committee (BRAC) was selection of service areas considered most critical to the elderly and disabled populations. Using the evaluation tool provided by DAAS, the group voted to focus on the following five service areas:

Transportation
Housing
Mental Health
In Home Aide
Home Health

Task 2:

The group unanimously decided the committee members needed education on the existing service. A leader was appointed to each service area with instructions to coordinate an informational presentation on the current status of the service at a designated meeting. This educational process continued from January until April 2004.

Task 3:

Once the committee members were equipped with a basic understanding of available services, the next step became the development of a Vision and Mission Statement.

NCDAAS contracted with Linda Rahjia to assist with this process for the May meeting.

Building a Responsive Community Vision and Mission Statement:

Vision Statement: To be a responsive community that recognizes the needs and choices of aging and disabled adults.

Mission Statement: To partner with consumers, families, providers and community to create a responsible plan that enhances and values the independence, personal choices and dignity for aging and disabled adults.

B: Evaluation of Five Critical Service Areas

The next phase of the BRAC project was evaluation of each service area identified as critical to these populations. Again, leaders from each service areas were appointed and instructed to use the Department of Aging and Adult Services (DAAS) tool to determine the current level of each service area. Sub-committees met from June through August 2004 studying six dimensions of each service area. These dimensions covered: existence, adequacy, accessibility, efficiency and duplications, quality and effectiveness. The time frame for the study was from May to September 2004. Each team leader compiled the committee findings into a written report and presented the information in a Community Forum September 28, 2004.

C. Development of a Strategic Plan

The BRAC committee is now in the process of solidifying a realistic long term care plan for the elderly and disabled populations. The committee has elected to concentrate efforts on the following areas:

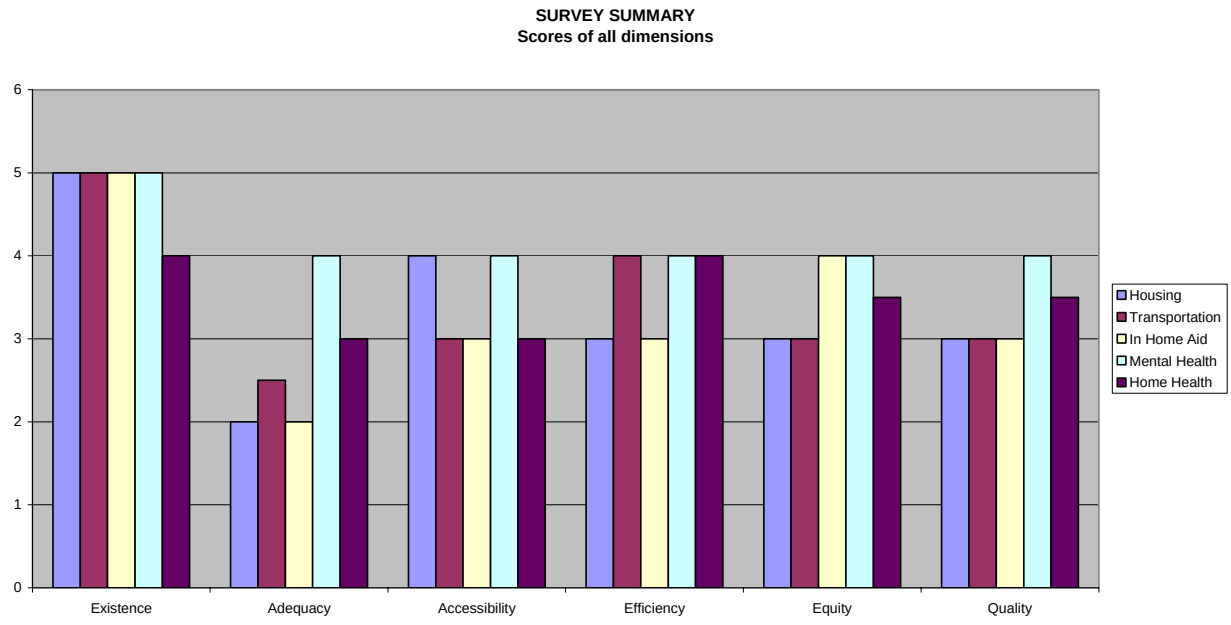
1. Advocacy/education for all services areas
2. Housing/universal design.

IV. Committee Service Area Reports

Over a three month period, each sub-committee met and studied the identified critical service areas. To accomplish this task they used an evaluation tool supplied by the NC Department of Aging and Adult Services. The tool dissected each service into six dimensions. The committee members supplied a numerical rating, from 1-5, to each dimension. The dimensions allowed an in-depth look at existence, adequacy, accessibility, efficiency and duplications, quality and effectiveness.

At the end of this analysis period, subcommittee leaders prepared a written report. On September 28, 2004 the committee leader presented their findings during a Community Forum held at the New Hanover County Department of Aging Senior Center.

The following graph provides an overview of the committee findings. The committee reports have been edited for the sake of space.



1. Transportation Committee Report

Public transportation services in Wilmington/New Hanover County are provided by the Cape Fear Public Transportation Authority (dba: Wave Transit). The new authority is the result of a July 1, 2004 merger of New Hanover Transportation Services (County) and the Wilmington Transit Authority (City). Wave Transit offers both fixed route and paratransit transportation services. Wave Transit is funded via support from Federal, State and Local Government.

In August, 2004, Wave Transit introduced a service expansion that included not only longer hours of service, but an additional day of operation. Residents of Wilmington/New Hanover County can now access transportation services Monday through Saturday from 6:30 a.m. to 9:30 p.m. Sunday services are available from 9:30 a.m. to 6:30 a.m. Additionally, shuttle services to Castle Hayne and Monkey Junction are available as well as services to limited areas of Brunswick County via the Brunswick Connector. All buses and vans are lift-equipped with proper restraints for transporting standardized wheelchairs.

A. Transportation Existence & Adequacy Rating
Existence
Rating = 5

The WAVE Transit system is available and equipped to transport older adults and persons with disabilities on fixed and paratransit routes throughout the county. The service area also has several taxicabs that are accessible to the elderly and disabled population. In addition, there are a few supplemental transportation programs provided by volunteer and/or faith-based organizations. The paratransit transportation service provides service for medical appointments (in and out-of-county), to senior nutrition sites and assistance with personal errands (grocery shopping, prescription pick-up, etc.). In July 2003 service for out of county medical appoints was added to the menu of services. Currently this service is utilized primarily for Medicaid patients.

B. Adequacy
Rating = 2 ½ or 3

There are several areas in our community that are underserved. Carolina & Wrightsville Beach, Porter's Neck and certain areas of Castle Hayne are included in this list of underserved categories. Additionally, there are several elderly and disabled housing developments that do not have access to public transportation (Gresham Place, Hermitage House, Plantation Village, etc.). WAVE Transit's new service expansion plan (began July 2004), increased the hours and days of operations to include weekends (Saturday and Sunday). The system's working relationship with New Hanover County Emergency Management and other members of the medical community make services available during severe weather emergencies for persons with critical treatment issues (dialysis, oxygen, etc.). Funding from the Federal, State and Local Governments does not financially support the cost of

needed route restructuring and the accompanying resource cost (physical, capital, etc.). In a recent transportation survey conducted by WAVE Transit, funding restrictions were determined to be a major barrier to transportation adequacy.

C. Accessibility
Rating = 3

All of WAVE Transit's system vehicles are equipped with accommodations for the elderly and disabled (lift-equipped buses/vans, seat belts, wheelchair restraints, kneeling bus/steps, padded grab bars, etc.). The fixed route buses are equipped with voice enunciators; paratransit vans are not. Because of inadequate sidewalks in various areas, bus stops are not accessible to the elderly and disabled without the risk of personal injury. Passengers who are developmentally disabled, sensory impaired or dealing with Alzheimer's disease have the option of riding a paratransit vehicle with a personal attendant (of their choice; there is no charge for the attendant. Because of the possible liability to the transportation system as a result of personal injury and/or theft, curb-to-curb services are provided as opposed to door-to-door. Dispatchers and drivers receive annual training in communicating with and assisting persons with special needs.

A new telephone system with one centralized number will be available by mid-October (2004). Fixed route maps are presently available in English and Spanish with pocket maps for each individual route; paratransit information is only available in English.

Large print maps (fixed route) are available upon request to assist visual impaired passengers. Fares for the elderly and disabled are as follows

Cash one-way :	$ .75
7-day pass:	$ 3.50
31-day pass:	$12.50
10 ride pass:	$ 3.50
Transfers:	FREE

D. Efficiency and Duplication of Services
Rating = 4

The paratransit division of Wave Transit is a coordinated human services system designed to meet the non-emergency transportation needs of the elderly, disabled and other special populations who are clients of area human service agencies. This greatly reduces the duplication of services among participating agencies. The paratransit division has a total of 27 vehicles which adequately meets the numerous and diverse demands for transportation services. Currently, the cost for participating agencies is $1.19 per mile. Out-of-county medical trips are coordinated with the Medicaid transportation unit of the NHC Department of Social Services.

Because of the high cost (resources & time) of "no shows", policies have been enforced to penalize habitual incidents. Clients are given a written copy of the "no show" policy and individual agencies are asked to thoroughly explain the importance of canceling unneeded trips to their clients. In

situations where “no shows” are continually excessive, clients risk totally losing their transportation privileges.

E. Equity
Rating = 3+

There are still areas of New Hanover County without access to public transportation (the beach areas, Porters Neck, Ogden, etc.) Funding will continue to play a large part in how soon uncovered areas will be served. However, with guidance from a short range transit plan prepared by Kimley-Horn & Associates, Wave Transit has begun plans to restructure all routes in the service region.

F. Quality/Effectiveness
Rating = 3 +

The Wave Transit Board of Directors is comprised of representatives from the City of Wilmington and New Hanover County. County Commissioner Nancy Pritchett and Mayor Pro Tem Laura Padgett both serve as members of the board. Additionally, at-large members of the human services community also serve. The Board of Directors meet on the second Thursday of every month at 12:00 noon in the Wave Transit Board Room located at 1110 Castle Street. All meetings are open to the general public.

G. Recap of Ratings
Overall rating = 3.4

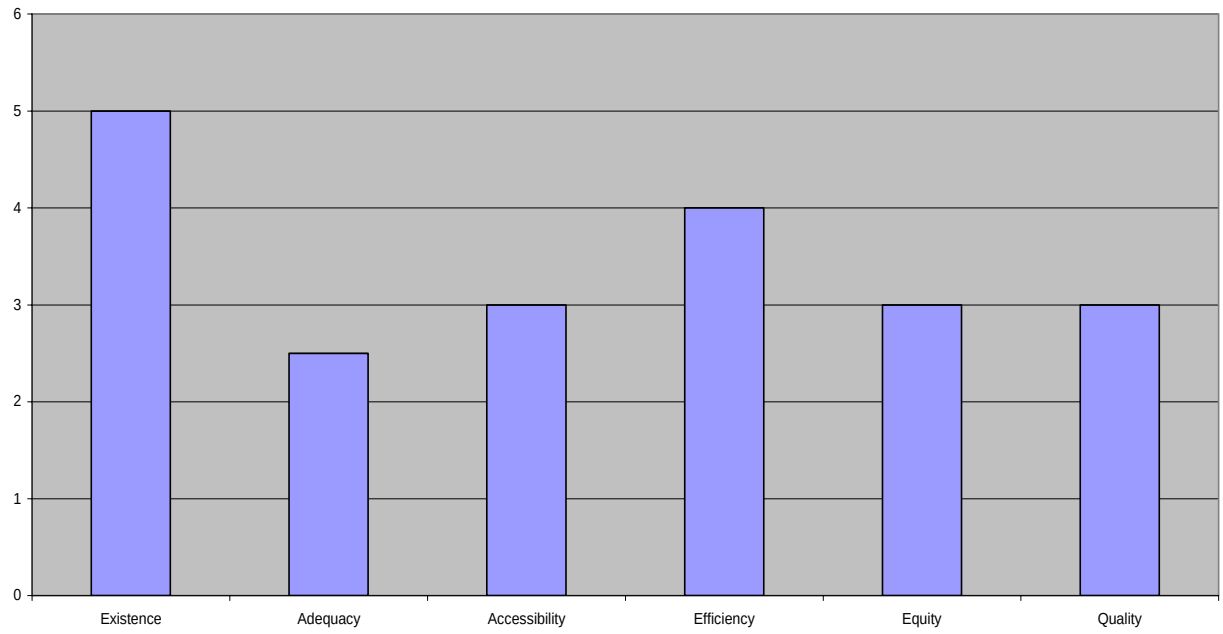
Although the transportation system has not been proactive in providing customer surveys for self-evaluation, this will change. WAVE Transit plans to conduct customer satisfaction surveys on an annual basis. In addition to the transportation system’s short range transit plan, yearly goals, objectives and performance measures are determined for overall system personnel.

The majority of complaints about the transportation system are received via telephone call. All complaints are investigated and handled immediately by the appropriate transportation improvement, especially in the area of customer service. Most of the complaints against the transportation system are related to late pick ups and/or arrivals to appointments. Currently, each human service agency contracting services with the transportation system monitors its service performance on a regular basis (daily, weekly, monthly).

Strengths: The merger between Wilmington Transit Authority and New Hanover County Transportation Services into WAVE Transit. The new authority will provide a more centralized transportation service delivery.

Barriers: Lack of adequate funding to support the needed growth in transportation service is the major barrier.

Transportation report prepared by Deborah Houston with assistance of Albert Eby, Eddie Weaver, Annette Crumpton, Lamont Jackson, and Kelly Clark.


TRANSPORTATION
6
5
4
3
2
1
0
Existence
Adequacy
Accessibility
Efficiency
Equity
Quality


TAXI

2. Housing Committee Report

A Existence:
Rating = 5

As we age, physical and mental abilities inevitably start to decline. Although many people are able to maintain high levels of physical functioning and mental acuity to very old ages, for many others the aging process results in a reduced ability to live independently. As a result housing needs may change as we age.

New Hanover County does have subsidized housing for elderly and disabled in each of the Wilmington Housing public complexes with two of these facilities, Solomon Towers and Glover Plaza being specifically for elderly and disabled persons. In addition, there are nine other subsidized housing developments for persons 55+. For persons needing more personal care there are twelve adult care facilities, seven family care homes and seven skilled nursing homes in the county.

There is existence of affordable housing for elderly thus a rating of five. The question becomes does the existing housing meet the needs of the elderly and disabled. The answer is no.

B. Adequacy
Rating = 2

Housing facilities for elderly and disabled have a standing waiting list. In addition, the wait list for Section 8 housing is more than two thousand people and at this time, the Housing Authority is not accepting applications. There are also waiting lists for home modifications (ramps and other interior changes), rental assistance, and help with heating and cooling bills.

For the disabled the picture is even worst. The cost, when available for handicapped accessible public rental units is $697 a month. There are no private housing units available for this population.

C. Accessibility
Rating = 3

The Department of Housing and Urban Development supports a broad array of subsidized housing programs for elderly persons of low and moderate income. For example, the Section 202 Housing Program for the Elderly and Handicapped provides below-market interest loans to private non-profit sponsoring organizations for the development of subsidized housing projects for the elderly. Financially qualified elderly tenants receive Section 8 rental assistance, and pay no more than 30 percent of their adjusted monthly income for rent.

As stated in the section on adequacy, the waiting lists are long and there are few if any outreach

activities provided for elderly and disabled. Although home modifications, assistance with bills and rent does exist, it is not adequate and thus not accessible to those in need.

The true accessibility issue of housing for low income elderly and disabled is ability, access to funds to cover cost of monthly rent. Most housing, other than public housing, is approximately six times the amount of the person's social security or disability check.

D. Efficiency and Duplication of Services
Rating = 3

There is not a duplication of services for repairs and modifications because there is basically no service available. There is a demand for low or no cost home improvement and repair but no funding to provide this service to low income elderly and disabled persons. Those living in public housing have a cap of $300 on repairs and modifications. Most agencies, such as the Department of Aging and Department of Social Services rely on the generosity of church and civic groups for this service. There is a small amount of Weatherization funding administered through the City of Wilmington.

E. Equity
Rating = 3

In general, services are offered to all people with no bias. The problem is lack of affordable adequate services and lack of funding to provide the services not discrimination. The disabled population is probably at more of a disadvantage than the elderly population.

F. Quality/Effectiveness
Rating = 3

Public housing has an advisory board that oversees and monitors its operations. Built into this is the opportunity for resident's councils, surveys and other means of communication between residents and staff. Wilmington Housing Authority is currently under going reorganizational changes and housing development. Jervay complex was demolished and is now being replaced with multi and single family dwellings. Taylor Homes is also facing the same demolishment and rebuilding phase. Once this construction is complete, the quality of homes will certainly be enhanced.

G. Recap of Ratings
Overall Rating = 3.18

Identified Barriers and Areas for Improvement in Housing:

Recognition of the diversity of elderly and disabled persons with functional impairments, both in their level of impairment, and in their ability to secure help without public assistance, is essential in developing policies that are responsive to the range of needs outside of the normal housing accommodations.

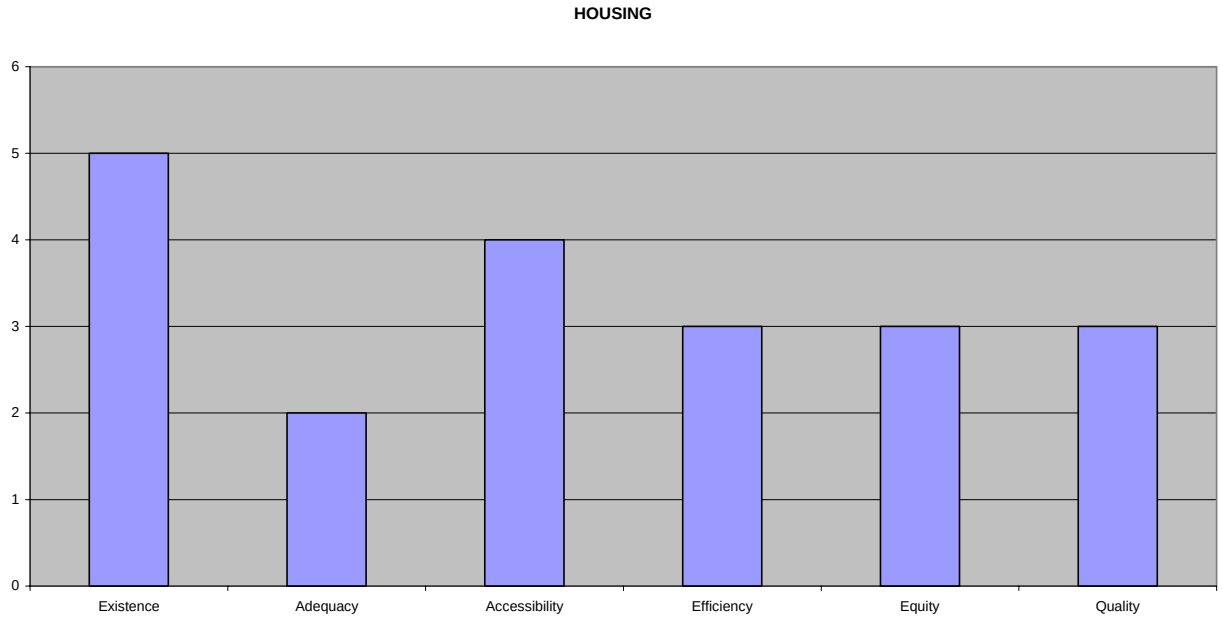
Lack of funds to build additional housing for these populations.

Limited recourses to provide home furnishing – Salvation Army, Habitat for Humanity

Limited funds through DSS for heating and cooling bills

Rental cost of the existing units is approximate six times the amount of the person' social security or disability checks.

Housing report prepared by Catrecia McCoy with assistance of Terry Brubaker, Margaret Craig, Harvin Quidas, and Walter Vincent.



3. Mental Health Committee Report

A. Existence:
Rating = 5

New Hanover County offers an array of mental health services for mental health, developmental disabilities, substance abuse and dementia/cognitive impairment. These services are available through the local mental health center, numerous private non-profit and for-profit agencies, individual providers and various support groups. In terms of the private sector, Wilmington offers over sixty private clinicians or counseling centers and fifteen private psychiatrists. The local mental health center, Southeastern Center for Mental Health, Developmental Disabilities, and Substance Abuse Services (SEC) currently contracts with 150 providers for approximately $14,000,000. Those persons with Developmental disabilities seem to have the most options for providers outside of the mental health center.

SEC for Mental Health, Developmental Disabilities and Substance Abuse services is the Area Program that serves Brunswick, New Hanover, and Pender counties. The Area Program serves a catchment area of approximately 1,918 square miles, with approximately 290,000 residents. This area is currently the third fastest growing catchment area in the State, with Wake County being first and Johnson County being second. Since the counties are all coastal counties and resort areas with very high tourism populations, the number of "potential consumers" of services increases during the summer months. SEC has maintained a strong commitment to providing a continuum of high quality services that meet the needs of the people in its catchment area and has developed and maintained a continuum of services for the three disability areas. SEC provides services to approximately 8,700 in New Hanover county (and 15,000 overall), has 330 staff and an annual budget of 42,000,000. Southeastern Center provides a continuum of services in the three (3) disability areas. These continuums of service include, but are not limited to:

- Prevention, Education and Early Intervention;
- Medication Assistance and Maintenance;
- Consultation;
- Periodic services to include individual therapy, group therapy, family therapy, psychiatric services, case management services, forensic services;
- Day services; e.g., psychosocial rehab.
- Therapeutic foster home;

As North Carolina is in the midst of reforming its mental health services and as this community is

beginning to divest services, the availability of services will likely appear different in the next years. SEC, now designated as a Local Management Entity (LME), will transition from providing clinical services and will provide initial access into the public system, authorize and monitor services, provide assistance and oversight to private providers, and insure the quality of services, rather than focusing on providing the array of clinical services. This community provides many services to those most acutely impaired. For example, this community offers an Assertive Community Treatment team for persons with severe mental illness who have not benefited from traditional mental health care. Many agencies have been working together for a number of years to form the Homeless Interagency Council whose mission is to collaboratively decrease the number of homeless persons in our area through the establishment of supportive housing and other services. Other collaborative efforts have brought permanent supportive housing and transitional housing projects together to improve the lives of the disabled. This community also has a strong emphasis on providing these services in the community, as much as possible.

This assessment focuses on persons who are accessing the public mental health system, as many with mental health, substance abuse and developmental disabilities utilize this system. It is also important to note that the mental health system has traditionally folded services to older persons within the specific disability groups. Thus, persons with Cognitive Impairments and Dementia would be seen in the Adult Mental Health program at Southeastern Center.

With divestiture, services in the public sector will focus on those who are severely disabled. It will fall to the community to develop support systems for persons who have no ability to pay for services and those uninsured who may not qualify for services in the public sector. This will be a concern as the reform moves forward.

B. Adequacy:
Rating = 4

With the exception of Developmental Disabilities services, there is not a waiting list for services for Mental Health, Substance Abuse or Dementia/Cognitive Impairment. There are currently two hundred clients waiting for DD case management and forty-five waiting for overall services. For the other services, although there is no formal waiting list, clients generally are not able to be seen immediately unless they are in crisis or present as a "walk-in." Consumers requesting Mental Health/Cognitive Impairment services must go through a phone screening (within 0-5 days).The time period is dependent on how quickly the client can be reached and have a follow-up face-to-face appointment. This appointment will be scheduled within 7-28 days. Clients requesting substance abuse services can be seen within one week and are then scheduled for follow-up between 30-60 days. Psychiatric services can be accessed within 2-3 weeks. For those persons with dementia that may be referred by their medical doctor, the psychiatrists can generally provide consultation without having to go through the assessment process.

Waiting for services can have detrimental effects. Twenty five to fifty percent of clients do not show for their initial appointments at the mental health center. Clients may have resolved the issue on their own, sought alternative treatment, or gone into a crisis requiring hospitalization.

One of the facets of Mental Health reform is insuring that system entry (screening, triage and referral) should assure ease of access organized through the Local Management Entity and respond to community members as quickly and accurately as possible. This includes a brief screening and triage to determine if a MH/DD/SA problem exists and to assess the urgency of the situation, in order for a referral to be made to the appropriate service. This access line, staffed by trained personnel, is available to all citizens of North Carolina 24/7/365 and toll free for those in the catchment area. The intention of access is to quickly link persons who are initiating mental health services. Once the need is identified, the level of acuity is determined. Those with emergent needs must be seen face-to-face within 2 hours, those with urgent needs within 48 hours and those with routine needs within 7 days. These requirements will greatly reduce the waiting time and improve care.

Twenty four hour/seven day a week emergency/crisis mental health services are available by Coastal Horizon's Crisis Line and face to face through the local emergency departments and through Southeastern Center's Crisis Station, which was established to assist clients in a psychiatric or substance abuse crisis for up to 23 hours. Generally, these folks need psychiatric hospitalizations, detox, may have severe symptoms or are a danger to themselves or others. This service has been invaluable to the community, as clients had to previously wait numerous hours in the local emergency department before being seen. Recently, the Crisis Station became "child friendly" by creating a designated segregated space for children that allows privacy from other adult clients who could be intoxicated or behaving erratically. Because the Detox is within the same building as the Crisis Station, clients needing these services have access readily available.

The Crisis Station does not meet the needs of all our consumers in crisis. For example, some clients (ie; children, consumers with developmental disabilities) may have behavioral problems that, according to family, reach a breaking point, and the Crisis Station may not fully address their needs. There is a Sheriff's Deputy staffed in the facility at all times. Clients are usually searched upon entry into the crisis station and although this is done for the safety of the facility, staff, and consumers, this search can make some folks uncomfortable. The deputy may handcuff those on Involuntary Commitment. These are persons that a magistrate or doctor has issued a legal mandate indicating the person as a danger to themselves or to others. Although this is again a law enforcement issue and for the protection of the clients and staff in the Crisis Station, there is understandably concerns about this practice.

For staff providing MH/DD/SA services, there is a wide range of expertise. Staff is generally Paraprofessional and Professional depending on the type of service provided. Generally paraprofessional staff requires training in providing care, a high school diploma and a clean criminal background check. For professional staff who are licensed and work as clinicians or psychiatrists, the licensure board requires clinical training and the State Personnel requires a specified years of experience. All providers provide and/or encourage additional trainings to improve quality of care.

New Hanover county has an extensive array of support groups including: National Alliance for the Mentally Ill-Wilmington, Al anon, Alcoholics Anonymous, Narcotics Anonymous, Wellness/Recovery, Autism Society, Alzheimer's, Family Caregiver Support program, Red Cross Caregiver Training Modules, Bereavement Groups, Traumatic Brain Injury Support Groups, and

others. Some meet weekly, others monthly and generally, they do not charge a fee for the group.

Funding for mental health services comes from Medicaid payments, State funding and Federal block grants. Medicaid is fee-for-service, state funding varies between the disabilities, and Federal block grants cover particular programs/services (for example, Women's Perinatal) as well as the federal portion of Medicaid. Overall, state funding for MH/DD/SA services have been under funded for years, meaning that the State funds used to provide services for those who meet criteria for public services and have no insurance is not adequate to fund the number of persons eligible. State funds run out six to eight months into the fiscal year. SEC has been able to shift funds generated by other services to cover the cost of services for these consumers.

C. Accessibility
Rating = 4

Southeastern Mental Health Center has been very visible in the community and is well known to providers, doctors, emergency room personnel, and law enforcement for the array of services offered. SEC has a long history of receiving referrals from primary physicians for consultation or to provide the psychiatric treatment. SEC offers prevention and education services, such as intensive education in schools regarding substance abuse and developmental disabilities. In addition, case management, Jail Diversion, Homeless program, Assertive Community Treatment Team services target specific populations. Our Homeless Case Manager provided outreach to 271 persons and actively worked with 49 clients last year. Community outreach programs include the National Alliance for the Mentally Ill-Wilmington, Mental Health Association-Cape Fear Chapter, Vitaline, Autism Society, Tileston Clinic, Interfaith Hospitality Network, Cure Aids of Wilmington, Good Shepard, Area Agency on Aging, Family Caregiver Advisory Council, Coastal Horizons and others. This community makes an effort to provide outreach where the older population and disabled are (i.e. nutrition sites, homeless shelters, schools, client's home).

Services in New Hanover County are fairly accessible. The transportation system is in the process of expansion which will certainly enhance the quality of the consumer's lives. The Mental Health Center is open regular business hours, with some limited evening hours, and offers a Crisis Station which operates 24/7 (even during hurricanes!). Since services are tailored for the specific needs of the client and family, they may include extensive evening or week-end coverage. Client forms at SEC are available in Spanish and there is a bilingual counselor. Both the New Hanover Mental Health Center and Developmental Disability Site on New Center Drive have TTY capability and SEC employs two Deaf/Hard of Hearing Specialists.

Most clients, regardless of disability are self-referred and may or may not be accompanied by family members. SEC handles the Involuntary Commitments for the county and folks brought in by the Sheriff's Department. Referrals may also come from primary physicians, private clinicians, the school system, Department of Social Services, local and State Psychiatric, Substance Abuse, Developmental Disability facilities, and others. SEC has a sliding fee and has been able to see persons regardless of ability to pay. The actual cost of services depends on the type of service and these costs are relatively the same across the state.

SEC has access to a pharmacy that has been able to offer Patient Assistance services for those who cannot afford medications. Eligibility is based on each particular drug company's specifications and may require a co-pay.

One of the challenges with Mental Health Reform is that mental health centers have been able to afford some of the services, such as the Crisis Station, and serve the indigent, because they provide an array of services and can cost shift to allow availability of money to cover cost of those who cannot pay. Smaller, private agencies will struggle to provide care for the indigent, psychiatric care, and after hours care.

D. Efficiency and Duplication of Services:
Rating = 4

There are multiple providers of mental health, developmental disabilities, substance abuse and cognitive impairment/dementia and costs differ depending on several factors: insurance, type of service, and public/private care. For those clients with Medicaid services are billed at the same cost across the state. Certainly, other insurance varies widely in allowable coverage. For those with no insurance and who meet target population, the cost of most services is the same across the state. There are some rates that are client-specific. It is important to remember that state funding is quite limited and generally has not funded an entire year of service. In terms of public and private care, there can be differences for those that are billing private pay even though there is a sliding fee.

Southeastern Center has been able to offer an affordable sliding fee because it has had the luxury of offering a wide range of services. Southeastern then turns these generated funds back into existing or expanded services to consumers. With mental health reform, many more providers will begin to offer services. This will increase both consumer choice and may offer some duplication of services.

Mental health reform also seeks to reduce the administrative costs of the area programs. The cost of billing, payroll, MIS, staff, and others has historically been paid by the funds generated by the clinical staff. The state is now paying area programs/LMEs to provide these and other services based on a rate related to the population of the community. Certainly the private providers who begin to offer services will still need to finance their own, albeit more limited, administrative costs.

The North Carolina State Plan 2004, Blueprint for Change, states that system entry (screening, triage and referral) should assure ease of access organized through the Local Management Entity (LME) in order to respond to community members as quickly and accurately as possible. This includes a brief screening and triage in order to determine if a MH/DD/Sa problem exists and to assess the urgency of the situation, so that a referral can be made to the appropriate services.

Access/Triage has historically been a clinical service provided as a phone or face-to-face by the Area Program, done by each disability and age-specific program. With the establishment of the Local Mental Entity (LME), access is now defined as a phone screening to determine if there is a mental health, developmental disability or substance abuse need and if the need is emergent, urgent, or routine. This access line, staffed by trained personnel, is available to all citizens of North Carolina 24/7/365 and toll free for those is the catchment area. The intention of access is to quickly

link persons who are initiating or resuming mental health services.

Following the Screening the referral or disposition is determined by the level of acuity. Emergent callers are referred to the Crisis Station immediately (or to the local emergency department). Urgent callers will be offered an appointment for assessment within 48 hours, and routine callers will be offered an appointment within seven (7) calendar days. This process should ease access into the system and insure consistency across the state.

Budget-extending practices are done by most agencies in this community. Southeastern center has two buildings that belong and are maintained by the county. The center also employs a grant writer who has successfully been awarded grants. For example, Southeastern employs a bilingual counselor as a result of a three year grant. The county has generously supported the mental health center and been instrumental with the Crisis Station, the ACT team, and a Supportive Housing case manager. The private agencies, particularly the non-profit, successfully seek donations and have been awarded funding from the city and county as well as private foundations.

Southeastern Center presently participates in numerous collaborative efforts throughout the three (3) county catchment areas. SEC is actively and consistently involved with local DSS, public health, schools, juvenile justice, guardian ad litem, law enforcement and jails, courts, homeless shelters, domestic violence programs, faith-based organizations, child and family teams, vocational rehab, local universities and community colleges.

In order to increase collaboration with affordable housing advocates, providers, and developers, SEC provides leadership and/or participation in the following collaborative efforts; Wilmington Housing Authority Partnership, City of Wilmington Mayor's Committee, NAMI Housing Committee, Supportive Housing for Persons with Disabilities Committee, Interagency Review Committee for Transitional Living Programs, and the Tri-County Homeless Interagency Council.

In order to identify and develop the local network of informal services for supportive housing, Southeastern Center will provide the following services that are not necessarily disability specific; a Housing Website, (www.wilmingtonhousing.org) providing updated lists of supportive housing currently available, a Housing Resource Center, providing updated printed copies of housing resources, specific program bulletins and requirements, Housing Authority Section 8 Guides, and housing rights information packets, a Housing Update Fax Service, providing monthly housing resource updates to more than 35 local service providers.

Southeastern Center and others seeks to develop and/or advocate for consumers to achieve maximum personal independence, using Best Practices, for the most appropriate supportive housing. SEC has identified that Supportive Housing for the elderly and disabled is key to improving and sustaining mental health and recovery. Therefore, in order to assure that a fair share of public resources are targeted to extremely low income persons with disabilities, many agencies provide participation and advocacy in the following areas: City of Wilmington Consolidated Plan (1 Year and 5 Year Plan); City of Wilmington CDBG and HOME funds workshops; Federal (HUD) Housing programs (Continuum of Care, Shelter + Care, PATH, Justice Program, Jail Diversion programs); Wilmington Housing Authority Annual Housing Plan; and Low Income Housing Tax

Credit Targeting Plans.

The Area Program Community Collaborative, serving Pender, Brunswick and New Hanover Counties, met Year One Benchmarks in July 2002. The community collaborative will continue to participate in collaborative projects to address the needs of target populations in New Hanover County.

Collaboration efforts in all three counties include; Department of Educations, Local Health Departments, and Vocational Rehabilitation. Additional efforts toward collaborations include participation of Southeastern Center on the Criminal Justice Partnership Board, Juvenile Crime Prevention Council, Communities That Care, and cooperation with 12 Step Recovery Programs (AA, NA, Al-Anon). All efforts enhance the opportunity for networking with community agencies to provide a continuum of care and access to resources.

Southeastern Center utilizes the case management model to identify, build upon, develop and monitor a network of informal services and supports needed to provide a foundation for individualized support and community integration at the consumer, family and community level; and clients are referred to community resources such as self-help groups, faith-based groups, vocational services, educational group, and support groups as indicated.

There is a directory listing the generic community resources that are available to provide services and supports in New Hanover, Brunswick and Pender counties: These services and supports encompass: Medical Services; Nutrition Services; Transportation Resources; Advocacy Groups; Local Employee Assistance Programs; Vocational Resources; Educational Resources; Shelters; Faith-Based Groups; Special Purpose Groups, such as Bereavement Groups; Leisure Activities; and Self-help Support Groups.

E. Equity:
Rating = 4

Mental health, developmental disability, substance abuse and dementia/cognitive impairment services for screening, emergencies, referral, and education are available to all adults throughout the county. Individual insurances may offer limits on particular services, such as individual therapy. Medicaid, which has always required medical necessity, now requires pre-approval for some services and reauthorization for most others. Those without insurance, seeking access to the public system, must meet the target populations, which differ by disability but generally focus on the most disabled. Priority is given to those who meet the criteria and also struggle with homelessness, co-occurring issues, are deaf/hard-of-hearing, or are leaving a state institution. Services include a basic package and enhanced services, reserved for the severely and persistently disabled.

The waiting list, and waiting time, limits availability for those with developmental disabilities. This also impacts the waiting time of appointments for others. Southeastern Center and agencies that contract and can access the state funding treat the indigent consumers identical to those who pay. If Southeastern offers a service, it is available to all clients regardless of whether their insurance covers the cost. With mental health reform, this availability does not seem to continue for those

LMEs in other counties who have divested services because private agencies cannot afford to have a large number of clients who have no ability to pay.

North Carolina has approved an Adult Medicaid direct enrollment for licensed clinicians effective January 2005. Until now, only psychiatrists could bill for Medicaid services and clinicians could bill through the physician. This change may increase the availability of services. On the other hand, presently only one psychiatrist in the private sector is seeing Medicaid clients.

New Hanover County is a fairly small geographic area and therefore services are centralized and within 20 miles of consumers. Certainly many services are community based and can be made accessible to clients in their homes, school, and workplaces.

In terms of prioritizing clients, all emergencies are seen within a two hour timeframe. Many other consumers present without an appointment with urgent needs and are seen the same day and as quickly as possible.

F. Quality/Effectiveness:
Rating = 4

In addressing the quality of services, the training of service providers is paramount. The provision of mental health, substance abuse, developmental disabilities and dementia/cognitive impairment services is performed by various disciplines which range in skill, training, and licensure. Some services, such as personal care and community based services can be done by paraprofessionals whereas clinical services are done by master and doctoral level licensed clinicians and board certified psychiatrists. Case managers should have a four year human service degree and four years of related experience. All qualified professionals may work with the specific disability area. Although there is not specific requirements for working with the older population, Southeastern Center employs a specialist with over twenty years of geriatric experience. With mental health reform and service provision moving out of the state personnel system and into the private sector, the LME will oversee the quality of services rather than directly provide, at least on the present scale.

Developmental disability services are monitored at least yearly. At present, other services are monitored based on complaints, critical incidents, or other concerns although the LME is going to be responsible for the routine monitoring of all service providers (with the exception of licensed clinicians and hospitals) in the catchment area. The clinical services of the area program are monitored yearly by the Division of Mental Health, Developmental Disabilities and Substance Abuse services by reviewing medical and financial records. The Division is also interested in other clinical services, such as client follow-up after discharge from the state facilities and compliance with the state anti-psychotic fund. Providers may also have accreditation such as COA (Council on Accreditation)

Southeastern Center, as the Local Management Entity for Brunswick, New Hanover, and Pender Counties, believed that the direct involvement of consumers, family members, providers, county agencies and other stakeholders in policy development and implementation is essential to the

operation of the LME.

It shall be the Policy of Southeastern Center to provide stakeholders, consumers, family members, and county residents the opportunity to provide input into policy formation and implementation through a number and variety of public mechanisms including but not limited to:

a) Representation of consumers and family member on the LME Board of Directors;
b) Representation of consumers and family members on selected LME Board Committees;
c) Availability of time at each LME Board meeting for stakeholders and community residents to address the Board;
d) Continuous communications between the administration, board and local advocacy groups;
e) Scheduled community meetings for education and planning purposes;
f) Local press and media coverage of services and activities;
g) Establishment of an on-going close relationship with our local Consumer and Family Advisory Committee (CFAC).

In 2002, SEC established the Consumer and Family Advisory Committee, comprised of 21 members, one from each disability and age areas and from each of the three counties as well as three at large members. The purpose of the CFAC is to have an active role throughout the LME planning process and an ongoing advisory role in the operation of the LME. These tasks include: advising and commenting on all local plans, making recommendations on areas of service eligibility, service array, and gaps in services, assisting in the identification of under-served populations, providing advice regarding the development of new services, reviewing and commenting on the local service budgets and implementation of local business plans, and participating in quality improvement activities.

Southeastern Center's Department of Supportive Housing, in collaboration with local advocacy groups (including NAMI, Ocean House Advisory Committee, Continuum of Care Grant Committee, and the Tri-County Homeless Interagency Council), conducts at least three annual community housing assessments to measure current supportive housing needs and to provide an inventory of current resources. These housing surveys will include the following:

• Annual Homeless Survey, to be conducted in March of every year. This survey includes more than 50 outside agencies in Brunswick, New Hanover and Pender Counties and will track current capacity, residency, and waiting lists for all agencies providing services to the homeless in the Tri-County area. The annual survey will also include a Point-In-Time Homeless Survey providing the total number of non-duplicated homeless persons being served in the area.

• Continuum of Care GAPS Analysis, to be conducted by June of every year. This annual needs assessment will provide an exact bed-unit inventory for all emergency shelter, transitional housing, and permanent supportive housing services provided by all agencies in the Tri-County area. This analysis will also provide a detailed breakdown of the unmet need (or gap) for bed-units, supportive services, and sub-populations for both individuals and persons in families with children.

Housing Questionnaire for Mentally Ill Consumers is conducted by September of every year. This

annual housing survey is sent to more than 100 mentally ill consumers in the Tri-County area to measure satisfaction with their current housing situation (anonymously).

SEC self-monitors through its Quality Assurance and Improvement Committee (QA/I) which assesses and strives to improve the quality of services. All providers who contract with SEC must have A QI plan. SEC recently hired a QI Director as part of LME who will oversee a community assessment and oversee outcome measures for services provided. In fact, SEC recently completed a preliminary community assessment in three counties to find the top five concerns of consumers, families, and providers. The DD program, at the request of the Area Board, completed an in-depth assessment of services and requested feedback from all consumers. SEC also gathers data which it sends to the Division through information collected at an initial intake assessment and subsequent follow-up. Yearly surveys are completed by area programs across the state. For five years, SEC has completed the Annual Homeless Survey and the Housing Questionnaire.

In order to ensure the appropriateness and quality of services being provided, these services will be monitored in multiple ways. Examples of service monitoring are consumer satisfaction surveys, case management and care management, record review and monitoring to include periodic assessment of clinical and functional outcomes, quality improvement plans required for providers and documentation of appropriate credentials and qualifications of providers.

Although complaints can be handled by a supervisor, SEC also employs a Client Advocate whose role is to advocate and facilitate concerns raised by our consumers. The nature of the complaint can vary from not liking a particular behavior, a clinician, and dissatisfaction with services, to more serious concerns.

System changes have been affected by surveys input from CFAC members, advocacy groups, consumer complaints, and the QI process. For example, the CFAC has strongly advocated for continuation of the patient assistance program and psychiatric services. SEC is dedicated to the services being evidenced based/best practice.

Best Practices will include the establishment and provision of a comprehensive array of services, such as case management, pharmacotherapy, Assertive Community Treatment teams, employment vocational services, psycho-education for consumers and families, crisis care, person-centered treatment planning, illness self-management and consumer operated services such as drop-in centers or peer support groups.

Part of Best Practice also includes the collaboration with other agencies to meet the basic needs of clients. Mental health cannot be achieved if someone has neither shelter nor food. Mental health reform includes focusing on the recovery from disability and this renewed focus seems to be empowering more consumers. In fact, SEC has more consumer involvement in all aspects of the system; and employs three Peer Support Specialists.

Psychosocial Rehabilitation Clubhouses (PSRCH) and Assertive Community Treatment Teams (ACTT) have been identified as Best Practices in the Adult Mental Health Services. SEC has had a PSRCH (Ocean House) and an ACTT in Wilmington NC, serving the residents of New Hanover

County. These services were open to residents of Brunswick and Pender Counties, but the distance and travel times involved were prohibitive and thus few consumers from the two rural counties had access to the services. Jail Diversion Services is also a "Best Practices" Model. SEC is implementing a Jail Diversion Program.

Recovery Services is a Best Practices Model. On September 29 and 30, 2003, SEC sponsored a two (2) day training session for staff, CFAC members and Stakeholders on the Recovery Model. SEC continues to implement Wellness Recovery Action Plans (WRAP) as a part of the services available to consumers. Forty consumer, staff and private providers have completed WRAP and many have moved on to participate in WRAP Facilitator training and Peer Support Training. SEC presently contracts with a Peer to teach the WRAP class.

G. Recap of Ratings
Rating = 4

Strengths/Weaknesses/Analysis and Methodology

Southeastern Center's strengths rest in its commitment to consumers, family members and stakeholders to provide and/or make available the highest quality and most appropriate services that the consumers need. That strength is represented in the continuum and quality of services provided to SEC consumers and is represented in the collaborations between SEC and other county agencies, including the health department, the hospital, the Department of Social Services, the school system, the courts, etc.

Southeastern Center's weaknesses rest in its current qualified provider network and in its development and use of specific outcome data and quality measures.

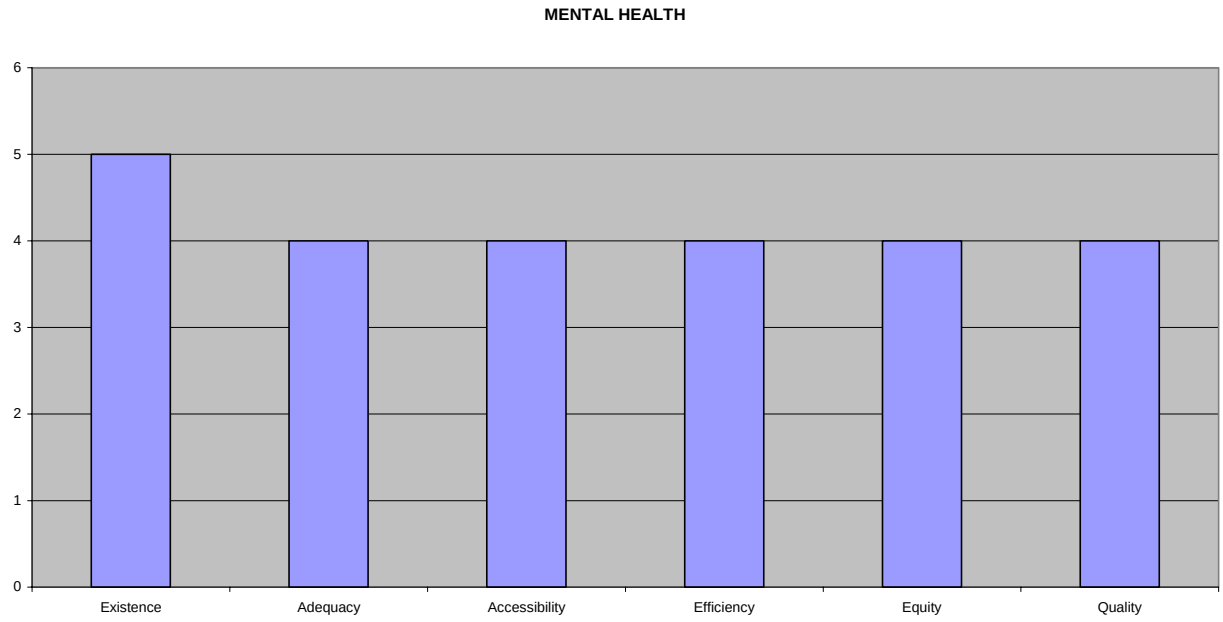
SEC will need to become much more active in recruiting and establishing a community of providers that can provide the services that are needed. The county agencies such as schools, court systems, etc. in all three (3) counties have come to trust and depend on SEC to provide the MH/DD/SA services that they need. Thus, SEC has numerous contracts to be the service provider in their agencies. Our community, consumers, agencies and advocacy groups are skeptical that SEC can establish a network of providers that will provide the quality of services that they have become accustomed to. Their skepticism is based on the fear that services they now receive may no longer be available to them. Thus, SEC has to retain the confidence and support of its consumers and stakeholders at the same time it is transitioning from an Area Program to an LME and to establishing quality community providers.

The area recognizes the skepticism that exists as based, in part, on the barriers to services that exist in a coastal community such as ours, and in part on lack of supportive data. We are committed to gathering as much hard data as possible to use as a means of educating our community as a whole, and to promote a positive attitude toward building a quality network of providers that will meet the needs of all within our catchment area.

SEC also needs to move in the direction of a Quality Improvement Model and to establish and use

more measurable outcomes and performance indictors. SEC has traditionally been dependent on a more typical Quality Assurance Model with an emphasis on demonstrated procedure and process, but with little measurement of performance outcomes.
In summary, the major challenges for SEC as it moves toward becoming an LME are 1) the establishment of a qualified provider network that will provide at least the same quality of services that our catchment area has received in the past, and has the confidence and trust of our consumers and other stakeholders; and 2) the establishment of a Quality Improvement Model with decisions, best practices, etc. based on measurable performance outcomes.

Mental Health report prepared by Carolyn Craddock, Linda Pearce, Merill Holden, Donald Crawford, Faye Kennedy, and staff from Southeastern Mental Health.



4. In Home Aide Services Committee Report

The In Home Aide Services subcommittee began their study by sending twenty-three (23) surveys to in-home aide providers in New Hanover County asking for information about their agency. Of the twenty-three mailed, eight surveys were returned.

The definition of in-home aide service is, "the provision of paraprofessional services which assist functionally impaired older and disabled adults with essential home management, personal care, and supervision necessary to enable the older and disabled adult to remain at home".

A. Existence
RATING = 5

There are currently approximately Twenty-three (23) in-home aide providers in New Hanover County. The choice of private providers is excellent due to the number of providers in our community. In-home aide services are available to older and disabled adults in our community, including persons with mental health issues, developmentally disabled and substance abuse problems. Our community also has providers that will assist persons at-risk of facility placement. The New Hanover County Department of Social Services began providing In-Home Special Assistance in October of 2003, specifically to provide services to at-risk individuals potentially in need of placement in Adult Care Homes, as well as assisting families receiving services in Adult Protective Services. Providers also provide services for CAP-DA, CAP-MR-DD, and CAP-AIDS recipients.

B. Adequacy
RATING = 2

There are currently sixty-eight (68) people on the waiting list for in-home aide services provided by the Home and Community Care Block Grant Fund to adults age 60 and older. The average waiting time is two years. Often they have died, or have been placed in a facility before services become available to them. Community Alternatives program (CAP) also has a waiting list. There is not adequate governmental funding available at the federal, state or local level to meet the current needs of our community for in-home aide services, notwithstanding the federally funded Home and Community Care Block Grant for adults 60 and over who are not Medicaid eligible, and funding granted to the Department of Social Services through the State In-Home Fund and the local county government. Funding sources also include private pay, private insurance, Medicaid, and grants. Private in-home providers did not report having a waiting list. Retention of the workforce appears to be problematic for providers. Turnover rate is high, hourly wage is low, and there are few benefits provided by private in-home aide providers

C. Accessibility
RATING = 3

Most referrals for In Home Services are made by physicians, hospitals, nurses and health agencies. Referrals are also received from family members and self-referrals. Outreach programs, and public information is offered to the general public though this is something that should increase. However, with increased awareness comes increased demand for service. In-home aide services can be cost prohibitive to those who must pay privately, and funding is limited for those who are not Medicaid eligible. If one is between the ages of 18 and 59, personal care services are not available to those who cannot pay privately and are not Medicaid eligible. The New Hanover County Department of Social Services' In-Home Aide Program is not certified to provide personal care services, so those who are not Medicaid eligible must pay privately, or other arrangements must be made.

D. Efficiency and Duplication of Services
RATING = 3

Costs are often prohibitive for consumers who are paying privately, but there appears to be a real effort to make affordable levels of care available for consumers who only need the most basic in-home aide services. Administrative costs range from 10% to 40% of the hourly cost of care. All levels of care are available. Cost of care increases with level of care. Cost of care per hour ranges are: $10.75 to $15.00 in Level 1, $10.75 to $15.00 in Level 2, $13.44 to $15.50 in Level 3, and $14.25 to $16.00 in Level 4. Cost of care in Level 4 for an LPN is up to $25.00 and from $30.00 to $35.00 for RN's. At one time, there was a county-wide in-home aide interagency which met to share information, education and for collaboration. There does not appear to be any sharing of expenses for training aides or cooperative agreements between providers.

Initial contact to screening takes two days on average. All providers reported referring consumers to other providers when they felt they could not meet the consumer's needs or if the consumer was not eligible for their services. Providers reported they refer from 2% to 20% of their consumers to other providers. Only one provider reported receiving funding from grants. Grant funding was 40% of their total revenue.

E. Equity
RATING = 4

Providers are able to cover all geographic areas in New Hanover County. The typical consumer as reported from our providers was white, female, 81+ years of age with a physical disability. The second largest age group was 71-80 years old, followed by the 60 to 70-year-old group. Blacks were the second largest ethnic group followed by Hispanics and lastly Asian. Only one provider acknowledged that there was a difference in their services to subsidized and private pay consumers. The difference being that they provided transportation to and from the doctor for the private pay consumers. Waiting lists are prioritized by date of first contact. Waiting lists are not prioritized by need. Only one provider reported currently having a waiting list. All providers reported having and following nondiscrimination policies. Both consumers and employees are made aware of these policies through orientation, handbooks, written forms, brochures, and admission packets. No

provider reported having any allegation of discrimination filed against them.

F. Quality/Effectiveness
RATING = 3

All providers are either certified, licensed or accredited. Fifty percent of the providers who responded to our survey reported that they paid for continuing education for their aides. There appears to be educational opportunities for aides both within the community and within the provider agency. The average hourly rate of pay for aides ranges from $6.75 to $8.00. Only one provider reported hourly wages higher than $8.00 per hour. Their rate of pay was $13.65. Most providers reported that there are opportunities for aides to move into jobs with more responsibilities. Fifty percent of providers reported offering health insurance, four providers reported offering mileage, and two offered educational stipends.

All the providers reported having surveyed consumers and their families to determine their satisfaction with in-home aide services through surveys, telephone calls and face to face. The majority of consumers reported that they were very satisfied with their services. All but one of the providers reported that funding sources regularly monitor their in-home aide services.

Complaints received last year ranged from zero to 10. All providers reported having a complaint resolution process. Complaints included scheduling errors, aides being rude and not following directions, aides being late, family not satisfies with aides, wrong personality, and aides being accused of stealing money but consumer refusing to prosecute. 96% of these complaints were rectified. Five providers reported making policy/program changes in the past five years as a direct result of consumer complaints.

Most of the providers reported hours and days of services from Monday to Friday from 8:00 A.M. to 5 P.M. All reported after hours services are available. Providers reported that 95% to 100% of their consumers receive services at the time they prefer.

Seven providers reported 100% of their aides have been trained with respect to cultural sensitivity with one provider reporting only 10% of their aides having been trained. Three of eight providers reported having complaints made against an aide in the past five years with respect to cultural differences. All providers reported assisting aides to deal with cultural insensitivity by the consumer through education and training, meeting with consumers, referring consumers to other providers and changing aides if needed. Three providers reported experiencing language barriers between aides and consumers. All but one provider reported communication with county commissioners and /or other government agencies concerning unmet needs of their consumers.

Three of the providers rated their back up plans for absent or delayed staff and transportation problems as good, two gave a rating of fair, and one provider each gave ratings of very good and excellent. Four providers rated their staff's competency to respond to situations such as abuse, malnutrition, and severe emotional problems as very good, two providers each reported ratings as good and very good. Providers reported from zero to 15 consumers in the past five years living in dangerous situations, were first recognized by their aides.

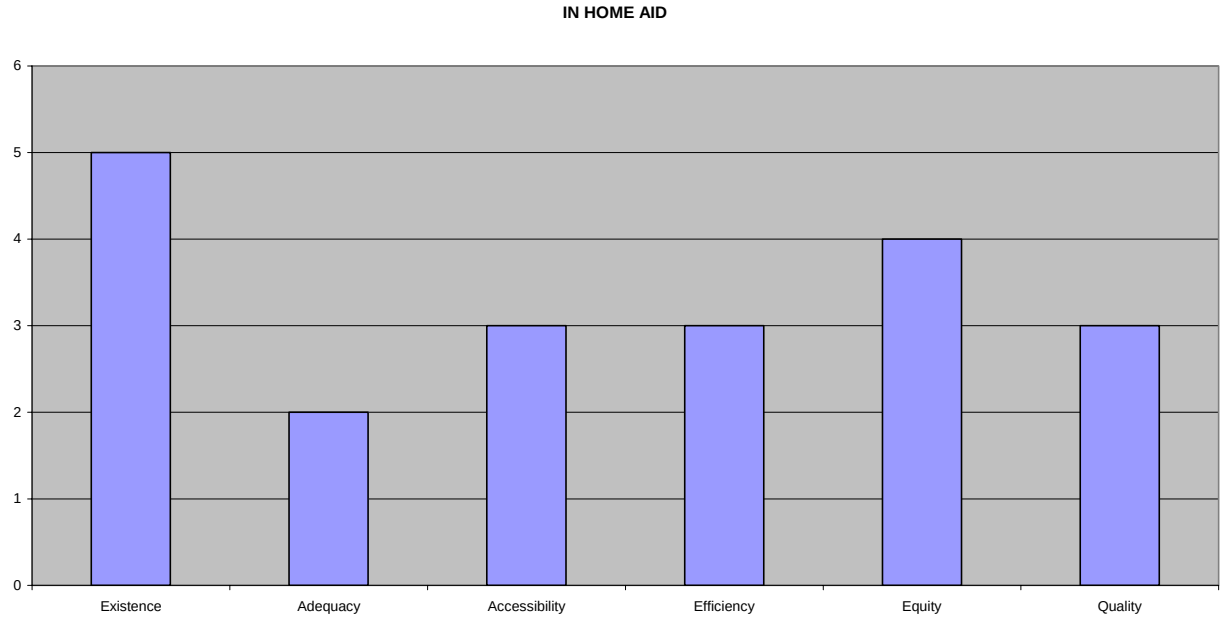
Providers reported that consumers can make decisions regarding whom their aide is, and hours worked. Consumers do not have input into hiring or firing decisions. Three of eight providers reported that consumers have input into their policies, regulations, and procedures.

G. Recap of Ratings
Overall rating = 3

Major Strengths of In Home Aide Services:
Major strengths include number of agencies available to provide services to all parts of the county providing good geographical coverage and providing all levels of care. Choice of private providers is excellent due to the number of providers in our community.

Identified Barriers and Area for Improvement:
Identified barriers and areas for improvement include: 1) Limited funding from federal, state and local governments 2) Low hourly wages and limited benefits for workers 3) Cost of care is prohibitive for private pay 4) Personal care services are not available for 18 -59 year olds if they cannot pay privately and are not Medicaid eligible.

In Home Aide Services report prepared by Susie Sprenger, with assistance of Athena Brown, Craig Magill, Gayle Ginsberg, Joanne Cain, and Melonice Williams.



5. Home Health Care Committee Report

Home Health Care is defined, (Taber's Cyclopedia Medical Dictionary), as the provision of equipment and services to the client in the home for the purpose of restoring and maintaining maximal levels of comfort, function, health, and safety of the individual. The equipment may be such things as oxygen, walker, wheel chair, communications devices, and anything that would enhance the restoration of the client. The services rendered may be skilled nursing, physical therapy, speech therapy, occupational therapy, medical social worker, and home health aide. The equipment and the services must be ordered by a physician and be medically necessary

A. Existence
Rating = 4

New Hanover County is very fortunate to have many agencies that are available to offer this care to its residents. Some agencies offer acute/short term as well as long-term services that accept public funding, such as Medicaid, Medicare and are enrolled with DMA. Other forms of payment for home health services are private insurance and private pay.

B. Adequacy
Rating = 3

There is no waiting list for home health because if one agency is unable to accept the client another agency will provide the ordered services. All services are available that staffing and equipment will allow. The outlying areas of the county are more difficult to cover. There is a lack of funding sources to cover personal assistance for clients in the home when a skilled care is not needed. There is never enough funding available to meet the needs of the older and disabled adult if they do not have Medicaid, Medicare, private insurance, or financial independence. The agencies receive a certain amount of funding from the state to provide services for indigent clients. This amount is not disclosed and it is different for each agency. Home health agencies are a viable alternative to nursing facility care on a short-term basis however, some cognitive clients choose not to use this service. The shortage of nurses has also made an impact in the home health arena. There are shortages that also exist in the area of the nursing assistant II and I. The salaries are not competitive with the hospital, the environments they work in are not always the best, and therefore the turnover is high. Therapy services usually have fewer turnovers however the supply is limited.

C. Accessibility
Rating = 3

Physicians that usually care for geriatric clients are aware of home health services; the others need some education regarding home health. Referrals are typically from the same source, i.e. the hospital, physicians' offices, or hospice. Clients and their families are not usually aware of home health services or its availability unless they have used the services before. There have been increased marketing efforts to inform the public and physicians about home health. If funding is available, (Medicaid, Medicare, private insurance or private pays), accessibility of home health in New Hanover County, if the client meets the criteria, is excellent. If the client is void of funding, there are very little home health services available. All of the Home Health agencies in New Hanover County are for profit agencies.

D. Efficiency and Duplication
Rating = 4

The cost of services is similar between agencies. Agencies are very competitive; they were not willing to share the cost of their services or their clients. Here is suggested cost to the client: skilled nursing, medical social worker, and therapies, is $125.00-155.00 per visit; home health aides, $55.00 per visit; and in home aides $14.00-20.00 per hour. Most administrative cost revolves around staff that does not generate income. The providers need to be prompt in screening the client (usually 48hrs.) to meet the criteria of the payment source. At times, the therapies screening can be delayed by limited staff and an excessive number of referrals for that therapy. The efficiency of the agency also depends on the number of staff, the education and orientation of said staff. Private-pay and subsidized clients receive the same care and services.

E. Equity
Rating = 3.5

Home health services are available to all of New Hanover County. These services are available to all residence but some cannot afford them if they do not have Medicaid, Medicare, or private insurance. All clients receive the same care whether they are subsidized or private-pay. The staffs of the providers are not educated in cultural differences. Interpreters are in short supply for home health agencies; many use the AT&T phone system to assist them. Special arrangements are required for the hearing-impaired clients and most agencies do not have them readily available. All providers have nondiscrimination policies

F. Quality/effectiveness
Rating = 3.5

The agencies are licensed and JCAHO OR CHAP. accredits some. All agencies send out client surveys, using their feedback to reflect changes in care. All complaints are documented and followed up with the client. When a client requires evening visits, these are more difficult to staff. All efforts are made to provide the visit time the client has request. All the agencies experience the same rate staff turnover. There are very little continuing education opportunities for the home health aides in the community; however,

each agency schedules their own continuing education for their home health aide staff. There is a state requirement of twelve hours of education per year for each home health aide. Wages for the home health aide are on the lower end of the wage scale. Many agencies offer benefits, (health insurance, mileage, educational stipends, and uniform allowances for their full time aides. Some aides are employed as per denim or on a "casual pool" status and are not eligible for benefits. Home health agencies do not communicate unmet needs of the county to the county commissioners.

G. Recap of Ratings
Overall rating = 3

Home Health Care's Major Strengths:

1 Allows the client to recuperate in his or her own environment.

2. Cost is less than an acute inpatient or nursing facility.

3. Offers the client skilled care that they may not get in an outpatient environment.

4. Different agencies offer different service options in the county.

5. Accessible to all in the area regardless of demographics.

Identified barriers and Areas For Improvements

1. Lack of relevant community outreach as opposed to "sales and marketing" of just referral sources.

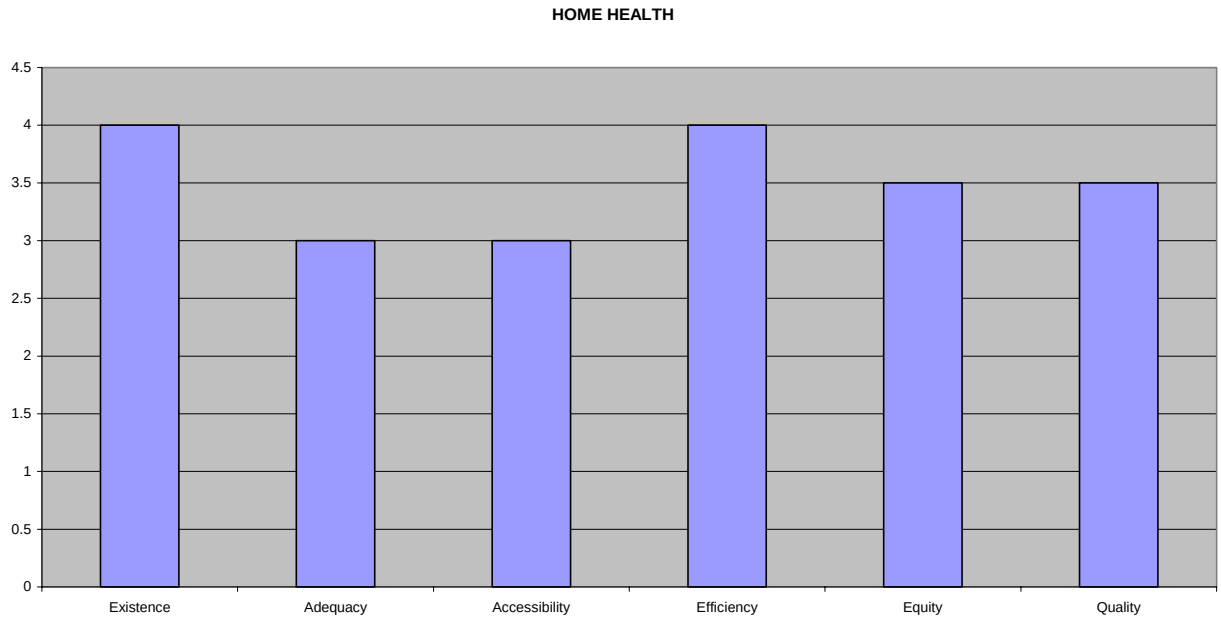
2. Inconsistency in visiting staff that affects continuity of client care and case management. Increased staff would improve this barrier

3. There is a lack of appropriate orientation and training for new or inexperienced personnel

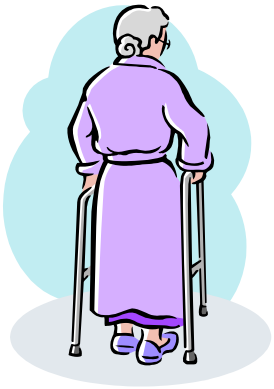
4 A comprehensive and extended orientation and a use of a mentoring system would improve the quality of care. This may be one cause for staff turnover that affects the quality of care.

5 Regular continuing education for all staff should be the norm.

6. Less focus on profit for the agency and more focus on quality of care.



Home Health report prepared by Elizabeth Grace and Leigh Ann McTavish with assistance of Diana Stewart, Dorothea Stone, Faye Kennedy, Holly Henderson, Sil Anderson, and Zorie Brown.



IV. Building A Responsive Community Public Forum

A Community Forum was hosted by the Building a Responsive Community committee, September 28, 2004 to report on the findings of the study (the five critical service areas) and to hear comments from the audience about needs for elderly and disabled persons. Approximately 85 people attended the forum, including local newspaper and TV media. Most of the dialogue between committee and audience concentrated on transportation and housing. It was discovered that the majority of the audience did not understand the difference between Home Health and In Home Aide services nor were they interested in learning about these services unless they or a family member needed the service. The public did state they appreciated the opportunity to voice their concerns and would like to have another forum in the near future.

The next task for the Building the Responsive Community committee was the development of an action plan based on the evaluation study. The committee wanted there plan to be realistic (realizing there was no available funding) and yet have an impact on the lives of the elderly and disabled citizens.

Two tasks were identified as the focus: (1) Encourage builders and developers to consider Universal Design in the planning and construction of housing, specifically housing units targeted for the elderly and disabled person (2) Education the community as to services that are available to these two populations so they can become stronger advocates for their needs. The advocacy efforts will focus on housing and transportation.

Two subcommittees have been established to work on the proposed plan

1. Advocacy/educational committee
2. Housing committee (Universal Design focus

V. Proposed Goals for Building a Responsive Community Committee

Goal I: **Education and Advocacy**

To educate the community, consumers and providers on services available to elderly and disabled persons in New Hanover and provide a voice for their needs.

Actions Steps:

- To conduct an annual Community Forum at the Senior Center
- To conduct area speaking engagements to civic, church groups and other community events four time a year
- To provide ongoing information on senior services on the County, City and University media, senior focused magazines and fact book

Outcomes

- Area seniors, caregivers and community will have basic knowledge of senior services and will know how to access the services
- 45% of the New Hanover County senior and disabled population will know how to access services by 2010. Senior Center will realize a reduction in number of daily telephone calls requesting basic information by 2010

Goal 2: Transportation Services

To increase accessibility of fixed route and paratransit transportation services throughout the county for older adults and disabled persons by educating and advocating for the needs of these population to the community, consumers and transportation providers.

Action Steps:

- Survey two senior/ disabled housing communities outside the city limits to determine current level of services and need for new and/or expanded services
- Continue agency dialogue with WAVE transit to provide more cost effective, efficient trips for older adults and disabled persons.
- Educate and advocate for change to WAVE Transit Advisory Board on the needs of senior and disabled adults for expanded fixed routes

Outcomes:

- Disabled and senior citizens living in the northern section of the county have access to fixed routes within reasonable distance of their home. (employment, personal trips other general transportation trips)
- More efficient medical paratransit service delivery for frail elderly and disabled persons by dividing the county into specific zone areas according to zip codes and utilizing a Geographic Information System (GIS) to plot routes and trips.

Indicators:

- 15% Decrease in requests for shopping/ personal transportation due to adequate

access to fixed routes by July 2008.

- More efficient scheduling of vans to achieve 10% lower cost of paratransit trips, less time spent in travel time by July 2006.

Goal 3 Housing and Universal Design

To educate and sensitize housing developers, architects, realtors and builders on the philosophy of livable communities and benefits of universal design to meet the needs of all populations

Action Steps:

- Meet with developers, county and city planners, architects, realtors, builders to discuss the need for accessible built environments through choice of options during the initial development phase that all allow for "growing into a house" with the focus "housing for a lifespan".

Outcomes:

- Universal Design options will be included on the builder/architect list of housing design options (just as fireplaces, etc are an option)
- All populations would have opportunity to consider Universal Design options when building/renovating homes

Indicators

- 10 % of area builders, developers, architects, realtor in NHC will include Universal Design options in their menu of housing options by 2010
- Expense to modify homes (grab bars/bath areas etc) in 2010 will be less when Universal Design options are used during initial construction period

"Building a Community that cares"